DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 4, 2023

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: CCN: 245587
Cycle Start Date: January 26, 2023

Dear Administrator:

On April 4, 2023, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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F 000	INITIAL COMMENTS On 1/26/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct mulitple complaint investigations. Ebenezer Care Care was found to be not in compliance with 42 CFR Part 483, the Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H55877838C (MN90327); however no deficiences were cited due to action taken by the facility prior to teh survey. The following complaint was found to be unsubstantiated: H55877853C (MN89254) Unrelated deficiencies were cited at F661 and F744. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments' acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		3/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/10/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 744	Continued From page 1 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop person-centered interventions to reduce behaviors and promote well-being for 1 of 1 resident (R1) reviewed with dementia who repeatedly displayed disruptive and aggressive behaviors which could place herself and/or others at risk for injury or harm. Findings include: R1's annual Minimum Data Set (MDS), dated 12/22/22, identified R1 had severe cognitive impairment and several medical diagnoses including unspecified dementia with behavioral disturbance, non-traumatic brain dysfunction and depression. The MDS outlined R1 was independent with bed mobility, transfers, ambulation, toileting and personal hygiene however, demonstrated no behavioral symptoms (i.e., verbal, or physical behaviors) during the review period. R1's care plan, dated 1/24/23, identified R1 had cognitive and behavioral difficulties due to poor cognition and dementia. R1 was recorded as being restless, walking the hallways (i.e., wandering), having sometimes aggressive behaviors towards staff members, and taking items from other residents' rooms. A goal was listed which outlined, " ... will have no evidence of behavior problems by review date," along with	F 744	F000 Submission of this Allegation of compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other Individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or constructed as an agreement with allegations of noncompliance or admission by the facility.	

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F 744	Continued From page 2 several interventions to meet the established goal including removing R1 or other residents from any unsafe situation or when R1 becomes disruptive; approaching resident slowly and calmy; maintaining a calm, consistent demeanor; monitor R1's whereabouts at all times; and to discourage naps during the day to allow R1 to sleep at night. On 1/26/23, at 10:57 a.m. and 11:30 a.m., respectively, R1 was observed to be laying in her bed with her eyes closed. There were no other residents in R1's room and R1 appeared without obvious physical symptoms of pain or discomfort. Further, there was no staff engagement witnessed with R1 during these periods. However, R1's progress notes, dated 11/15/23 to 1/26/23, identified the past 72 days of recorded behaviors for R1 while at the nursing home. These included the following: On 11/15/22, R1 was re-admitted to the nursing home after being hospitalized for behavioral symptoms which, at times, required intramuscular medication and restraints to control. On 11/17/22 at 8:02 p.m., R1 was separated from another resident during dinner for raising her voice at the other resident. On 11/23/22 at 4:00 p.m., R1 was documented to be physically aggressive towards staff and other residents, attempting to hit them with a hand sanitizer bottle R1 had pulled off the wall. This resulted in 911 being called. R1 was taken to the acute care hospital but released back to the facility on the same day with no new orders.	F 744	This plan of correction is not to be constructed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for Medicare and Medicare programs. F 774 1.Corrective Action: Resident (R1) has not harmed self during escalation of behavior. The policy on abuse prevention was reviewed with no changes. 2.Corrective Action as it applies to other residents: All current residents with challenging behaviors will be discussed by interdisciplinary team to identify ensure behavior interventions are addressed, appropriate and behavior summary completed. All residents will be assessed for behaviors on admission, quarterly. annually, significant change and as needed. Behavior interventions will be patient centered. 3.Date of Completion: March 12th,2023 4.Reoccurrence will be prevented by: Random chart audits will be conducted by the DON or designee to ensure that behavior summary is documented according to care conference schedule. 3 random chart audits will be completed weekly for 4 weeks, then 2 random chart audits per month for 2 months. Audit	

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F 744	Continued From page 3 On 12/5/22 at 11:20 p.m., R1 was documented pacing the hallways and entering other residents' room. On 12/6/22 at 6:00 p.m., R1 was documented as "calling names and being verbally aggressive." On 12/6/22 at 10:17 p.m., R1 was recorded as agitated, calling staff "idiots" and shouting loudly. On 12/11/22 at 9:31 p.m., R1 wandered into another resident's room and urinated on the floor. On 12/27/22 at 2:53 p.m., R1 was recorded as agitated, and stealing another resident's art. On 1/1/23 at 1:18 p.m., R1 pulled down her pants in the dining room and urinated in her walker basket. On 1/2/23 at 1:53 p.m., R1 was recorded as confused and agitated. R1 grabbed another resident's walker and attempted to hit the other resident. On 1/2/23 at 9:20 p.m., R1 wandered into another resident's room and became very upset attempting to punch, kick and bite at staff. R1 locked and barricaded herself into the room, and she required multiple staff members to remove her. On 1/3/23 at 11:50 p.m., R1 was recorded as wandering and entering other residents' rooms. R1 left the unit and became agitated and yelled when redirection by staff was attempted. On 1/4/23 at 2:57 a.m., R1 had entered another resident's room and urinated on floor. R1 was	F 744	results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring. 5.The Correction will be monitored by: The Director of Nursing/ Director of Social Services or designee.	

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found sitting on the other resident's bed by staff when they entered the room.

On 1/8/23 at 4:56 a.m., R1 was recorded as having wandered in the hallways until 2:00 a.m., and then had been found in another resident's room.

On 1/10/23 12:03 a.m., R1 was recorded as wandering into other residents' rooms.

On 1/14/23 at 2:04 p.m., R1 was recorded as wandering room to room, and she attempted to hit staff and residents.

On 1/19/23 at 5:40 p.m., R1 was documented wandering in the hallway and entering R2's room. According to R2, R1 entered her room and took one of R2's teddy bears. R1 pushed R2 to the ground when R2 attempted to get her teddy bear back. A subsequent note, dated 1/19/23, identified R1 would be reviewed for a significant change in status MDS due to her increased " ... socially inappropriate behaviors."

On 1/22/23 at 2:46 p.m., R1 was documented as continuously wondering into other residents' rooms and "urinating all over the place."

On 1/23/23 at 1:26 p.m., R1 was reported being combative with staff during activities of daily living.

In addition, on 1/20/23, the interdisciplinary team (IDT) reviewed the resident-to-resident altercation with R1 and another resident (see note dated 1/19/23). A section of the note identified a 'root cause' for the incident which outlined, "[R1 has] ... diagnosis of dementia and wanders into other

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F 744	Continued From page 5 residents' rooms. She is not aware of what belongs to her or others." However, the note lacked any further assessment of R1's behaviors, including over a period of time to review for trends, patterns, or potential triggers, despite the repeated notes of R1 wandering and, at times, being physically aggressive with staff and other residents. In total, the completed progress notes identified 20 episodes of behavioral symptoms (i.e., aggression with staff and residents, wandering, and urinating in inappropriate places) for the period of notes reviewed. Of these recorded behaviors, three (3) episodes occurred on the 'day shift' (i.e., 6:00 a.m. to 2:00 p.m.); nine (9) episodes occurred on the 'evening shift' (i.e., 2:00 p.m. to 10:00 p.m.); and eight (8) episodes occurred on the 'night shift' (i.e., 10:00 p.m. to 6:00 a.m.). The pattern of more behaviors occurring on the evening and night shifts was acknowledged by the administrator on 1/26/23 at 1:15 p.m. when interviewed. R1's physician order indicated R1 was receiving several medications for her mental health and well-being. These included Trazadone (an antidepressant medication) 25 milligrams (mg) every evening with an additional 12.5 mg dose at bedtime as needed (PRN) dated 11/15/22; and Risperidone (an antipsychotic medication) 0.5 mg twice a day with an additional 0.5 mg dose daily as needed dated 11/28/22. The last medication change noted in R1's record was 12/19/22, when R1's sertraline was decreased from 150 mg daily to 100 mg daily. In addition, on 12/13/22, R1 had an as-needed order for Zyprexa (an antipsychotic medication) renewed on 12/13/22, with a stop date of 12/26/22. The record lacked evidence this	F 744		

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F 744	Continued From page 6 order was renewed and/or current at the time of the abbreviated survey. R1's Medication Administration Record (MAR), dated 1/1/23 - 1/26/23, identified R1 received PRN Trazadone 12 times since 1/1/23, with administrations being recorded on 1/1/23, 1/8/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/15/23, 1/16/23, 1/18/23, 1/22/23, 1/24/23, and 1/25/23. Further, the MAR indicated R1 had received PRN Risperidone four times since 1-1-23, with administrations being recorded on 1/2/23, 1/3/23, 1/4/23, and 1/22/23. R1's Psychiatric Progress Note, dated 1/18/23, identified R1 had been seen a month prior with "no changes made" at the time. The note outlined R1 as being 'rigid' with her behaviors, however, had not been disruptive " ... in the sense of aggressive behaviors." The psychiatrist identified, "I do not believe that she has required [as needed] Risperidone." A mental status examination was completed which outlined R1 as being currently soiled (i.e., incontinent), with poor insight and judgment. A section labeled, "Assessment," identified R1 as having dementia and a history of irritable personality. R1 had a history of "multiple episodes" of agitation and aggression in 2022, which at times, required hospitalization. The assessment concluded, "She has had a few changes, but overall seems to be stable." Further, a section labeled, "Suggest," outlined different approaches or interventions for staff to attempt or be aware of. These included, "[R1] may respond well to positive incentives for changes ... might include things like Dr. Pepper or wine coolers, something she used to get. If this could be arranged, I do think it would be helpful." However, R1's medical record lacked evidence	F 744		

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this had been acted upon or considered by the nursing home thus far.

R2's annual MDS indicated she had moderate cognitive impairment. When interviewed on 1/26/23 at 10:58 a.m., R2 recalled the altercation between herself and R1 from 1/19/23. R2 explained it was around 8:00 p.m. when R1 had entered her (R2) room and started playing with her stuffed animals. R1 wanted to take them and became upset when R2 protested and tried to take them back from her which caused R1 to push her (R2) causing her to fall on the ground. R2 stated she was "scared to death" of R1 since the incident and expressed the situation remained concerning to her. Further, R2 expressed she didn't seem to feel the staff did anything to help the situation and had heard other residents yell for help when R1 enters their rooms.

On 1/26/23 at approximately 11:30 a.m., an interview was completed with nursing assistant (NA)-A and NA-B. NA-A stated R1 has lived at the facility for about 3 years and used to be independent. R1 still ambulated with or without a walker but required assistance with all other activities of daily living (ADLs). NA-A and NA-B expressed R1 had behaviors, and NA-B stated, "We have to keep other residents away from her (R1) when she is out in the common area (due to her disruptive behaviors)." NA-A and NA-B stated R1 often takes things from other residents and staff let R1 take the object to her room until she calms down. NA-A stated R1 has a doll that can sometimes help to calm her down; however, if that doesn't help the staff merely just try their best to calm R1 down by talking with her or giving her space. NA-A and NA-B further stated that since R1's hospitalization approximately one month ago

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F 744	Continued From page 8 her behaviors have become worse. They are at times fearful of R1's aggressive behaviors and will only provide cares for her if two staff members are present R1's entire medical record was reviewed. The record lacked evidence R1 had been comprehensively assessed for her behavioral symptoms, or even attempted prior to 1/19/23 after being re-admitted on 11/15/22 despite the need for emergency room care intervention on multiple occasions, to include identification or evaluation of observed patterns, trends, or other extrinsic factors which could exacerbate them (i.e., increased behaviors on the evening hours). There was no evidence demonstrating the facility had identified, assessed and responded or adjusted the care plan with specific, person-centered interventions on the evening or night shift prior to the resident-to-resident altercation on 1/20/23; despite multiple recorded behaviors during these periods, the psychiatry note (dated 1/18/23) outlining potential interventions to consider to reduce the risk of altercations, and the prescence of these behaviors since R1 returned from the hospitalization (on 11/15/22). Further, the medical record lacked evidence the cessation of R1's as-needed Zyprexa order, on 12/26/22, had been assessed for need or subsequent re-start despite these ongoing physical behaviors. During an interview on 1-26-23 at 11:45 p.m., licensed practical nurse (LPN)-A stated she does see aggressive behaviors from R1. LPN-A stated if R1's behaviors are affecting other residents, staff try to separate them but usually staff back off when R1 gets aggressive. LPN-A further indicated there is nothing different on R1's care	F 744		

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F 744	Continued From page 9 plan for evenings but staff did have a meeting about a month ago on how to approach and care for R1. If R1 becomes physically aggressive they notify the DON and the physician. On 1/26/23 at 1:30 p.m., the director of nursing (DON) and licensed social worker (LSW)-A were interviewed. DON stated behavioral symptoms were assessed using an interdisciplinary model and, if a concern was raised (i.e., behavior), it was reviewed at their IDT meetings which were held every morning and included other various disciplines. LSW-A explained they recognized an escalation of R1's behaviors back in October 2022 and, at the time, R1 did not consume any psychotropic medications. However, due to the behaviors, medication was subsequently started. Then, on 11/10/22, R1 had behaviors which the nursing home could not control, and she was hospitalized; being re-admitted on 11/15/22. The DON confirmed there was no formal comprehensive assessment completed or recorded for R1's behavioral symptoms (including patterns, trends, etc.); and they both acknowledged the medical record demonstrated increased and more frequent behaviors on the evening shift without any specific care planned interventions to address them for the time of day. However, the DON added, "Staff is aware she has issues at night because they are monitoring her." The DON stated she felt the direct care staff did verbal reports and "just know" to monitor her more closely in the evening hours; however, acknowledged they had not assessed for the need or considered doing one-to-one monitoring or even periodic safety checks (i.e., 15-minute checks) for R1 during these hours. DON and LSW-A expressed such interventions would be "unrealistic" due to staffing considerations despite	F 744		

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F 744	Continued From page 10 them being informally (i.e., not documented) done during waking hours. The DON expressed they tried to not have unfamiliar staff work with R1; however, explained multiple staff members had been injured by R1 and her behaviors since she returned from the hospital. The DON added, "This is why this resident needs to go somewhere else." Facility policy Vulnerable Adult - Abuse Prohibition Plan revised on 10-6-22, indicated that the facility has "Zero Tolerance" for resident abuse, neglect, and mistreatment with a goal to provide, " ... our residents with a safe, secure environment free from maltreatment." A facility' policy on dementia care was requested, however, was not received.	F 744		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/26/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Ebenezer Care Center was found to be in compliance with the MN State Licensure requirements.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	C 01/26/2023

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2 000	Continued From page 1 The following complaint was found to be substantiated: H55877838C (MN90327); with no licensing orders issued. The following complaint was found to be unsubstantiated: H55877853C (MN89254) The MDH documents the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245587	A. BUILDING: _____ B. WING _____	**1/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive discharge summary, including with appropriate medication reconciliation, was completed and provided to help promote continuity of care for 1 of 2 residents (R4) reviewed for discharge planning. Findings include: R4's progress note(s), dated 1/11/23 to 1/17/23, identified the following: On 1/11/23, R4 admitted to the nursing home from an acute care hospital with a primary diagnosis of respiratory failure. R4 had orders for physical and occupational therapy. On 1/12/23, a nutritional note was entered which identified R4 consumed a consistent carbohydrate with regular texture. On 1/13/23, a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) was issued to R4. An anticipated date of discharge was listed as 1/16/23, however, recorded, "[R4] stated if he feels like it." A subsequent note on 1/13/23, identified the licensed social worker (LSW)-A met with R4 to discuss discharge plans and obtain information. R4 responded, "Why you need to know that [expletive]?" I handle my own [expletive]. Everyone just needs to stay out of my own [expletive]." R4 maintained his desire and intention to discharge on 1/16/23. On 1/16/23, R4 was discharged from the nursing home in stable condition. The note concluded, "Denied any

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Continued From Page 1

new questions or concerns."

R4's Nursing Home Visit - Progress Note, dated 1/13/23, identified R4 was seen at the nursing home after admission for a face-to-face prior to discharge on 1/16/23. R4's medical history was outlined which included chronic obstructive pulmonary disease (COPD) and diabetes mellitus. Further, a section labeled, "Assessment and Plan," outlined R4 had a history of ground coffee/red-colored orogastric tube output during his hospitalization. However, the NP determined R4 was at low risk for an acute gastrointestinal (GI) bleed and directed, "Will restart PPI [proton pump inhibitor] in this patient on chronic steroid therapy."

However, R4's corresponding Discharge Instructions and Recapitulation Version 3.2 V11- V 5, dated 1/16/23, identified several sections to be completed to outline R4's stay at the nursing home and post-discharge needs. This included a section labeled, "Primary Care Information," which listed R4's primary care physician, however, lacked any contact information for them. The summary identified R4 was not interested in receiving home care services but rather, " ... plans to check in with care coordinator who will further assess needs and offer waivered services as appropriate." The summary continued and outlined a section labeled, "Nutritional Discharge Instructions," which listed several fields to record R4's nutritional needs and interventions post-discharge including diet and supplements; however, all of these fields were left blank and not completed. In addition, a section labeled, "Medications," listed several fields to record R4's pain medication consumption, reconciliation (i.e., admission versus discharge orders), and if medications were sent with the resident upon discharge or returned to the pharmacy. However, the fields to indicate medication reconciliation and disposition of the medications were left blank and not completed. There was no evidence on the completed discharge summary supporting R4's medications had been appropriately reconciled to ensure R4 was discharged with the correct medication orders despite the Nursing Home Visit - Progress Note (dated 1/13/23) which identified R4 was to resume his PPI medication. The summary concluded with signatures of LSW-A, a registered nurse (RN), and a licensed practical nurse (LPN). A separately scanned copy of the summary, also dated 1/16/23, identified R4's signature on the summary.

On 1/26/23 at 11:53 a.m., the director of nursing (DON) and licensed social worker (LSW)-A were interviewed. LSW-A explained the discharge summary was completed using a "multi-disciplinary" approach and all applicable sections, including dietary and medication reconciliation, should be completed. The DON expressed the nurse who completed the form was a pool-agency nurse and she was unsure why the sections were left blank adding, "It's hard for me to say." LSW-A and DON verified the discharge summary should be completed, and LSW-A expressed it was important to help ensure the discharged resident had information on their care needs "moving forward" from the nursing home. The DON added, "The goal is to integrate care."

A provided Discharge Plan and Recapitulation policy, dated 9/2022, identified discharge planning started upon admission and listed several areas of the discharge summary and the corresponding role' responsibility to complete them. This outlined, "Medications: (Reconciliation of pre-discharge medications with patients post discharge mediations [sic] (both prescribed and over the counter) Completed by Nurse Manager and may be delegated to Nurse. Teach back method."

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